APPLICATION FOR PERMIT TO ADMINISTER ANESTHESIA AND SEDATION FOR DENTISTS

State Form 46159 (R / 2-06)
Approved by State Board of Accounts, 2006

INDIANA STATE BOARD OF DENTISTRY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2057
E-mail: pla7@pla.IN.gov

INSTRUCTIONS: Please type or print.

FOR OFFICE USE ONLY		
Date application received (*month, day, year*)	Application fee	Date fee paid (*month, day, year*)
Receipt number	Permit number	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

I am applying for the following permit, *(Please check appropriate box below .)*

☐ General Anesthesia and Deep Sedation *(includes authorization to administer Light Parenteral Conscious Sedation)*

☐ Light Parenteral Conscious Sedation *(only)*

Name *(Last, first, middle, (maiden)*

Address *(number and street or rural route)*

City, state, and ZIP code | E-mail address

Primary office address *(number and street or rural route)*

City, state, and ZIP code

Telephone number ( )

Date of birth *(month, day,*

Social Security number *

* This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1, in order to perform its statutory function.

DENTAL DEGREE (S) GRANTED

Name of school | Dates attended (*month, day, year*)

Location of school

EDUCATION AND TRAINING

(To be completed by applicants for General Anesthesia - Deep Sedation or Light Parenteral Conscious Sedation Permits)

General Anesthesia - Deep Sedation Permits / Advanced Education Program

Name of school | Dates attended (*month, year to month, year*)

Location of school | Degree received

Date certification / degree was granted (*month, day, year*) | Program title

Light Parenteral Conscious Sedation Permit / Training and Education

To be completed by applicants if: ***predoctoral training was obtained***

Name of school | Dates attended (*month, year to month, year*)

Location of school

To be completed by applicants if: ***postdoctoral training was obtained***

Name of school - hospital | Dates attended (*month, year to month, year*)

Location of school - hospital

Program title | Number of hours of instruction | Number of patients managed

WHERE DO YOU INTEND TO ADMINISTER GENERAL ANESTHESIA, DEEP SEDATION, LIGHT PARENTERAL CONSCIOUS SEDATION	
List all offices - hospitals where you currently intend to administer : *general anesthesia*	
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)

List all offices - hospitals where you currently intend to administer : *deep sedation*	
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)

List all offices - hospitals where you currently intend to administer: *light parenteral conscious sedation*	
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)

List all states in which you have been licensed to practice, including the license number and date of issuance.		
Name of state	License number	Date of issuance (*month, day, year*)
Name of state	License number	Date of issuance (*month, day, year*)
Name of state	License number	Date of issuance (*month, day, year*)
Name of state	License number	Date of issuance (*month, day, year*)

ADVANCED CARDIAC LIFE SUPPORT INFORMATION	
List the date you were most recently certified in advanced cardiac life support or received certification as an instructor in advanced cardiac life support (*month, day, year*):	Date of issuance (*month, day, year*)
State the name and location of the entity where you received your training in advance cardiac life support	
Name	
Location	

+ PLEASE SUBMIT DOCUMENTATION VERIFYING YOUR CERTIFICATION WITH YOUR APPLICATION.

DISCIPLINARY INFORMATION

Has disciplinary action ever been taken regarding any dental license you hold or have held ? *(If yes, provide information below and submit a sworn statement giving full details.)*	☐ Yes ☐ No
State	Charge
Date (*month, day, year*)	Disposition
Are you now, or have you ever been treated for drug or alcohol abuse? If yes, submit a sworn statement giving full details.	☐ Yes ☐ No
Have you ever been convicted of, pled guilty or nolo contendere to: ● a violation of any federal, state or local law relating to the use, manufacturing, distributing,or dispensing of controlled substances or of drug addiction ? ● any offense, misdemeanor, or felony in any state ? *(except for violation of traffic laws resulting in fines.)*	☐ Yes ☐ No ☐ Yes ☐ No
If yes to either offense above submit a sworn statement giving full details. Include the violation, location, date and disposition.	

I hereby swear under penalties of perjury that the above statements are true, complete and correct.	
Signature	Date (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

To whom it may concern:

I hereby authorize, request and direct any person, firm officer, corporation, association, organization or institution to release to the Professional Licensing Agency or the Indiana State Board of Dental Examiners any files, documents, records or other information pertaining to the undersigned, requested by said Board, or any of its authorized representatives, in connection with the processing of my application for a permit to administer anesthesia or sedation.

I hereby release the aforementioned persons, firms, officers corporations, associations, organizations and institutions from any and all liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency and the Indiana State Board of Dental Examiners to disclose to the aforementioned organizations, persons, institutions any information which is material to my application, and I hereby specifically release said Agency and Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

VERIFICATION

I hereby swear under penalties of perjury that the above statements are true, complete and correct.	Date (*month, day, year*)
Signature	Print name

EMERGENCY EQUIPMENT SAMPLE AFFIDAVIT

This type of affidavit must be completed and submitted by all applicants for a permit. **This is a sample.** Please prepare your own affidavit. Your office must contain the listed emergency equipment. If your office contains additional emergency equipment please list it also. You must submit an equipment affidavit for each office location where you will administer *general anesthesia deep sedation or light parenteral conscious sedation.*

Photocopies of this sample will not be accepted by the board.

I, _____ ,

Indiana Dental License Number _____ being duly sworn upon my oath do hereby swear or affirm that

my dental office located at _____
(number and street, city, state, and ZIP code)

Contains the following emergency equipment:

(1) A portable oxygen system capable of delivering positive pressure highflow oxygen (i.e., ambu bag, Robert Shaw Demand valve, or equivalent), full face mask and oral and nasal airways.

(2) An emergency source of power which can be utilized in the event of a power failure and is sufficient to operate the equipment and

(3) A suction apparatus capable of aspirating gastric contents efficiently from the pharynx or mouth.

(4) An electrocardiograph.

(5) A laryngoscope and assorted blades.

(6) Endotracheal tubes in assorted sizes.

(7) Drugs necessary to follow advanced cardiac life support protocols.

(8) Equipment for continuous intravenous fluid infusion to facilitate drug administration.

(9) A stethoscope.

(10) A body temperature measuring device.

(11) A defibrillator.

(12) A pulse oximeter.

FURTHER AFFIANT SAYETH NAUGHT.

Signature

NOTARY CERTIFICATE

STATE OF _____

COUNTY OF _____ } SS:

I, _____, having been duly, say that I am the above-named applicant, that I have personally prepared the foregoing affidavit, and that the same is true to the best of my knowledge and belief.

Signature of applicant	Signature of Notary Public	
Printed or typed name of applicant	Printed or typed name of Notary Public	
Date subscribed and sworn to Notary Public (*month, day, year*)	County of residence	Date commission expires (*month, day, year*)